undergone tracheotomy at the age of 30, had died aged 80, and had worn the tube during the intervening time. Despite the *a priori* physiological arguments as to the importance of warming inspired air in the nasal passages, he knew of people who, while wearing their tracheotomy tube, played tennis, begat children, and did all the other things the ordinary citizen accomplished, except swim! Moreover, they did not seem more subject to bronchitis than were other people. The malignancy in Mr. Howarth's case was of a low form, and he (the speaker) thought that an operation might be performed, which, as regarded severity, would lie somewhere between laryngo-fissure and complete laryngectomy.

Mr. C. A. SCOTT RIDOUT said that he had shown at a previous meeting a patient with a similar condition. This patient had progressed well and was quite cheerful, having had no trouble at all, though since the operation he had suffered from an acute attack of appendicitis. He had never had a cold in the head since the throat operation.

Mr. LIONEL COLLEDGE said that in the first of these specimens the epiglottis had been left; in the second it had been removed with the larynx. On close examination the growth was seen to approach closely the cut edge of the epiglottis. It was better, when removing the whole larynx, to take away the epiglottis at the same time. In some of his own cases, on examining the patient with the mirror, the epiglottis had appeared to be free, but afterwards, in the specimen, it was seen to be deeply infiltrated. With regard to drainage, he had not found gauze drains efficient. He used rubber tubes instead, and as soon as there was much discharge he syringed the tubes through with eusol; a simple rubber tube having lateral holes was the best form of drain.

Sir JAMES DUNDAS-GRANT said that in a case in which he had seen Mr. Lionel Colledge operate, the existing tracheotomy wound was adherent to the surface of the neck, and Mr. Colledge had cut through the trachea above it, bringing the skin together behind the cut surface of the trachea, so that he was then able to plug it until union was established and so to protect the lungs from infection—the patient breathing through the tracheotomy tube. Might not this safeguard be more frequently adopted?

Mr. LIONEL COLLEDGE (in reply to Sir James Dundas-Grant) said that a preliminary tracheotomy allowed the cut end of the trachea to be packed so that the trachea was completely shut off. But in three cases in which there had been preliminary tracheotomies there had been recurrence in the tracheotomy wound, and he wondered whether making an additional wound there before doing the main operation did not expose the patient to an additional risk of recurrence.

Dysphagia for Three Months due to Foreign Body in the Œsophagus.

By C. GILL-CAREY, F.R.C.S.Ed.

History.—Patient, a woman of 32, complained of inability to swallow solid food for three months. Could not remember having swallowed a foreign body. Had lost 2 stone in weight.

Examination.—No abnormality in larynx; no excess mucus in the pyriform fossa.

X-ray examination by Dr. Graham Hodgson, who reported an abnormal opacity in the œsophagus between the sixth and seventh cervical vertebræ.

Œsophagoscopy.—Piece of glass, a portion of which is shown, removed from the œsophagus 25 cm. from incisor teeth. No ulceration of the œsophagus was present.

Complete recovery after removal of the foreign body.

Dr. ANDREW WYLIE (President) said that he had seen the patient in this case, and she had complained very little. Mr. Gill-Carey had removed the foreign body in a very skilful manner. It was uncertain at the time of the operation whether a foreign body was present.

Lymphosarcoma of the Tonsil and Tongue with Glandular Involvement.

By NORMAN PATTERSON, F.R.C.S.

PATIENT, aged 64, female.

History.—Eight years ago the patient noticed swellings on the left side of the neck. Later on she was treated at the London Hospital by X-rays, and the enlargement of

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glands disappeared after six months. About two years ago the swelling re-appeared, but the condition improved under treatment. The glands began to enlarge again last summer. The patient has lately been under medical treatment.

On examination there is found to be a large, smooth, firm mass in the region of the left tonsil and there is a similar swelling involving the lingual tonsil. There are enlarged glands on both sides of the neck, and the pre-auricular gland on the left side is distinctly swollen. There is also enlargement of a small gland in the right axilla.

Microscopic Diagnosis.—Lymphogranuloma (so-called large-celled lymphosarcoma). Slide shown.

Discussion.—Sir JAMES DUNDAS-GRANT asked whether radium might be used in this case.

Mr. PATTERSON (in reply) said that the growth had become somewhat generalized.

Growth in Larynx.

By W. H. KELSON, M.D.

H. J., AGED 32, male. Noticed that he became hoarse intermittently soon after demobilization in 1920. Has never had to strain his voice.

Larynx shows general congestion. A roundish, pinkish, mobile swelling, about ¼ of an inch in diameter, can be seen in the region of the anterior commissure attached to the right vocal cord. Tonsils enlarged, but no enlarged glands noticed. No history of syphilis. No tubercle bacilli found in sputa.

Mr. E. WATSON-WILLIAMS thought this might be a granuloma. He had seen five such cases, all in pensioners. When examined after removal, there was no fibrous structure, it was granulation tissue. This growth should be easily removable with the forceps.

FURTHER REPORT OF CASES PREVIOUSLY SHOWN.

Sarcoma in Cricoid Region.

By G. W. DAWSON, F.R.C.S.I.

PATIENT, aged 58, female, married. (Shown at meeting held December, 1926.)

History.—Tightness of throat began last Christmas; later difficulty in breathing and laryngeal stridor. Has been treated for asthma. Wassermann negative. There is a smooth, round tumour covered by normal coloured mucous membrane, situated below the right vocal cord. Both vocal cords and arytænoids move well. Voice normal.

December, 1926: Urgent tracheotomy. Owing to slight bronchial trouble operation postponed to January 4, 1927. Laryngo-fissure. Round-celled sarcoma in cricoid region. Secondary hæmorrhage eight days later. Patient died January 15, 1927.

Mr. DAWSON said the general view, when this case was shown, had been that the growth was an enchondroma. It was a soft growth in the region of the cricoid. He had split the larynx, and it did not appear white, as it had done on laryngoscopic examination. He excised a piece, and the report was that the growth was round-celled sarcoma. The patient went on very well for eight days, then secondary hæmorrhage occurred, and was repeated, and on the following day he died.

Perforation of Hard Palate.

By A. L. MACLEOD, M.B.

MALE, aged 69. The patient has worn a tooth-plate for years. For five years liquids and soft foods get into the right nostril. There is a perforation of the hard palate which the exhibitor suggests is due to pressure atrophy. There is no sign of a neoplasm, but in view of the possibility of malignant trouble, he would be reporting himself every month.